

Miami County Health Department

Death Certificate Request

Name at Death: _____

Date of Death: _____

Name at Birth: _____

Date of Birth: _____

Place of Birth: _____

Father's Name: _____

Mother's Maiden Name: _____

Mail to: _____

Address: _____

Street

City

State

Zipcode

Your Signature: _____

Today's Date: _____ Your Phone Number: _____

Enclose a photocopy of your drivers' license and a money order for \$15.00 per certificate made payable to the Board of Health and send along with this completed form to:

Miami County Health Department
Attn: Registrar
35 Court Street
Peru, Indiana 46970

In order to process your request, this form must be filled out completely and a copy of your driver's license must be enclosed.